

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

	Date of onset
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

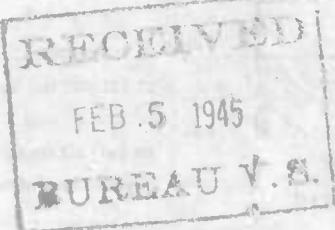
	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago

BUREAU V.S.

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00786

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County... Queen Anne
City or town... Centreville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alexander Brown

4. Sex Male | 5. Color or race Colored | 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Carrie ?

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years 1879

8. AGE: Years 66 Months | Days | If less than one day hrs. min.

9. Birthplace Brownsville 2006 Md (Town, county, and state)

10. Usual occupation Farm hand

11. Industry or business

12. Name Thomas Brown

13. Birthplace Brownsville 2006 Md

14. Maiden name Ellen Ryan

15. Birthplace Brownsville 2006 Md

Mannie Harris

16. Informant Cemetery Maryland

Address Burial Date thereof Jan 26-45

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Brownsville

Location Brownsville Maryland

18. Funeral director Boaston Bros

Address Centerville Maryland

19. 1-26-45 Eli Armstrong

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (Brownsville)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13 1944, to Jan 24 1945

and that I last saw h. alive on 19.

Immediate cause of death

Natural Regurgitation

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

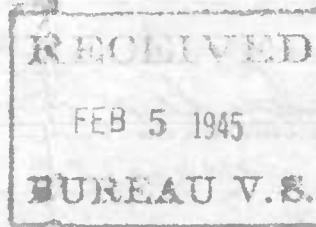
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Henry Fisher

M. D. or other

Address Centerville Md Date signed 1/25/45



PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

00787

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

Dungen Annex
County Centreville

City or town (If outside city or town limits, write RURAL and give nearest town)

25 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Percy A. Clark

4. Sex

Male white single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 21 - 1903

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

41 11 22 hrs. min.

9. Birthplace Stearnsville 2d Co. Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Jerry Clark

MOTHER FATHER

12. Name Jerry Clark

13. Birthplace Stearnsville, Md.

14. Maiden name Matie Thomas

15. Birthplace Stearnsville, Md.

16. Informant Mrs Helen E Walker

Address Centreville, Md.

17. Burial Date thereof Jan 12 - 45

(Burial, cremation, or removal. Which?) Stearnsville

(month) (day) (year)

Cemetery or crematory

Location Stearnsville, Md.

18. Funeral director Barton Bros.

Address Centreville, Md.

19. Jan 12 - 1945 Elsie Armstrong

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

none

3. (b) Social Security Number

214-12-6277

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on

Immediate cause of death

Asphyxiation -

Due to fire, coal oil

burn, on fire, 1 day

Due to explosion, spallors

to clothes & bed.

Other conditions Burns degree

Injuries

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause fill in the following:

Accident, suicide, or homicide

Where did injury occur? Centreville

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Exploding oil

Injured at work? No

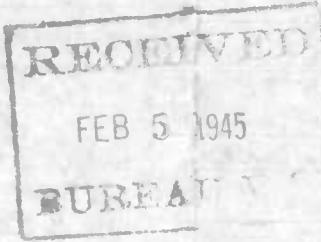
23. SIGNATURE

Samuel White M.D.

M. D. or other

Address Duxbury medical office

Date signed Jan 12, 1945



M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12-2

00788

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County..... Queen Anne

City or town..... Kingston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Samuel Thomas Cranor

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

B.(b) Name of husband or wife..... Ada Cranor

7. Birth date of deceased (mo., day, yr.) April 20, 1859

8. (c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
85	8	12	hrs. min.

9. Birthplace..... Cecil Co. Maryland
(Town, county, and state)

10. Usual occupation..... Farmer (retired)

11. Industry or business

FATHER	12. Name..... Eli P. Cranor
	13. Birthplace..... Md.

MOTHER	14. Maiden name..... Annie Shelton
	15. Birthplace..... Md.

16. Informant..... Miss. Bessie Duyer
Address Chestertown, Md. (R.F.D.)17. Burial..... Date thereof Jan. 4, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Crumpton Cem.
Location..... Crumpton, Md.18. Funeral director..... J. Willis Wells
Address Chestertown, Md.19. Jan. 3 1945 Edgar S. Lane
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Queen Anne

City or town..... Kingston

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 2 1945 at 6:9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-19 1944, to 1-1-1945

and that I last saw him alive on 1-1-1945

Immediate cause of death..... Organic heart trouble

DURATION

Due to..... Regurgitation

Due to.....

Other conditions..... N.P.P.

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

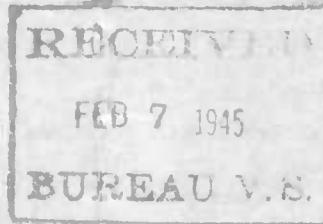
Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... H P Capeland M.D.

M. D. or other

Address..... Chester, Md. Date signed 1-2-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

00789

Reg. Dist. No. 251

1. PLACE OF DEATH

County.....

Queen Anne Co

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 days

Hospital, institution, or street address where death occurred

How long in hospital or institution?.....

3. (a) FULL NAME

Nathaniel E. Crosshaw

4. Sex

F M

5. Color or race

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Edward S. Crosshaw

6.(c) If alive, give age years

Aug 26, 1889

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

Years

Months

Days

If less than one day

hrs.

min.

8. AGE:

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19.45

Edgar L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Queen Anne

City or town..... Barclay

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 20 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20 1945 to Jan 22 1945
and that I last saw him alive on Jan 20 1945

Immediate cause of death

Coronary Occlusion

Due to

Grand Arterial Occlusion

Due to

Drabolin Myelitis

Other conditions

Chemical myelitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

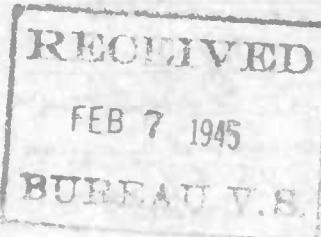
23. SIGNATURE

① M. L. Lane

M. D. or other

Address

Patterson Bay 1/22/45 Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83d

00790

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: Queen Anne

County:

City or town: Mr. Cuttrell's

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Marchelle Belle Harrison

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) Jan 31 - 1870

6.(c) If alive, give age

years

8. AGE: Years Months Days It less than one day

74

11

11

hrs.

min.

9. Birthplace: Wiliamsburg, Va Co., Md

(Town, county, and state)

10. Usual occupation: Hair Dressing

11. Industry or business:

William Harrison

12. Name: William Harrison

13. Birthplace: Va Co

14. Maiden name: Amanda Price

15. Birthplace: Queen Anne Co

16. Informant: Mr. Joseph Bradip

Address: 6 Centreville, Md

17. Burial: Queen Anne

(Burial, cremation, or removal. Which?) Date thereof: Jan 13 - 45

(month) (day) (year)

Cemetery or crematory: Greenmount

Location: Hillside - Md

18. Funeral director: Barton Bros

Address: Centreville, Md

19. 1-12 - 1945 Elin Armstrong

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Centreville P.T.S.

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10

1945 at 10:50 AM

21. CERTIFY that death occurred on the date above stated: the attended deceased from

Dec. 1944 to Jan. 10 1945

and that I last saw h. u. alive on Jan. 9 '45 1945

Immediate cause of death:

Hemorrhage

Due to:

Due to:

Hypertension

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

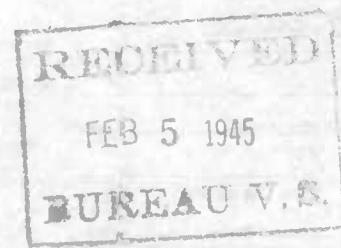
Means of injury:

Injured at work?

23. SIGNATURE:

H. J. Matherne M. D. or other

Address: Centreville, Md Date signed: 1/14/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age of deceased is shown on

FILM NO. G 93 MAR 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

00791

CERTIFICATE OF DEATH

Reg. Dist. No.

254

1. PLACE OF DEATH:

County Glasgow

City or town Glasgowville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all of life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Heath

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Chas Heath (deceased)

7. Birth date of deceased (mo., day, yr.) June 10-1876 8. (c) If alive, give age 67 years

8. AGE: Years 68 Months 7 Days 18 If less than one day hrs. min.

9. Birthplace Glasgowville Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business None

12. Name John J. Gruer

13. Birthplace Glasgowville Md

14. Maiden name Nancy Griffin

15. Birthplace Glasgowville Md

16. Informant Dorothy Griffin

Address Glasgowville Md

17. Burial Date thereof Jan 30-46
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or crematory Bethel Chapel Cemetery

Location Glasgowville Md

18. Funeral director John D. Williams

Address Bethel Md

19. Jan 30 46 H M Aldridge
(Date rec'd by registrar) LSC. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Stevens County

City or town Glasgowville Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

more

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1944 to Jan 28 1945

and that I last saw her alive on Jan 27 1945

Immediate cause of death

Arteriosclerosis

Due to Anemia a doctor

Due to coronary Sclerosis with

Other conditions coronary occlusion

DURATION
about 2 years

6 months

2 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

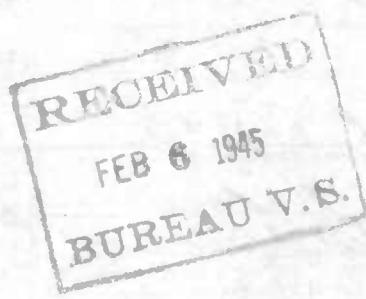
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Theodor Battelauer M. D. or other

Address Stevensville Date signed Jan 29 1945



M

MARGIN RESERVED FOR BINDING

1

2

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

00792

CERTIFICATE OF DEATH

Reg. Dist. No. 73-3

1. PLACE OF DEATH:

County..... Queen Anne
 City or town..... near Stevensonville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John M Holden

4. Sex

Male	5. Color or race	White	6.(a) Single, married, widowed, or divorced	Married
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6.(b) Name of husband or wife

Ruth a Holden

7. Birth date of deceased (mo., day, yr.)

May 3 - 1888

(c) If alive, give age 50 years

8. AGE:

Years	Months	Days	If less than one day
56	7		hrs. min.

8. Birthplace

Queen Anne Co

(Town, county, and state)

10. Usual occupation

Fanner

11. Industry or business

James E Holden

MOTHER FATHER

James E Holden

J. A. Co

14. Maiden name

Eima May Coney

15. Birthplace

J. A. Co

18. Informant

Mrs Ruth Holden

Address

near Stevensonville

17. Burial

Date thereof Jan 4 - 45

(month) (day) (year)

Cemetery or crematory

Stevensonville

Location

Stevensonville Park

18. Funeral director

Taffy Lene

Address

Frank Hill

19. Date rec'd by registrar

19. 45

Sc C Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Queen Anne
 City or town..... near Stevensonville
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945 at 500 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw h..... alive on 18.....

Immediate cause of death.....

Bronchitis Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

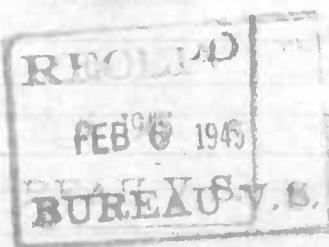
Means of injury.....

Injured at work?

23. SIGNATURE..... Samuel Price M.D.

(Specify medical experience) M. D. or other

Address..... Date signed 1/1/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

00793

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County..... Queen Anne's
City or town..... Stevensville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma Frances Legg

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Wm. H. Legg

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 10 - 1862

8. AGE:

Years

Months

Days

If less than one day

83

0

13

hrs.

min.

9. Birthplace

Caroline - Md.

10. Usual occupation

Housewife

11. Industry or business

12. Name

John S. Russum

13. Birthplace

Caroline Co. Md.

14. Maiden name

Angelina Jarman

15. Birthplace

Caroline Co. Md.

16. Informant

Mrs. Russum Legg

Address

Stevensville Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Jan. 26 1943

(month) (day) (year)

Cemetery or crematory

Stevensville Cem.

Location

Stevensville Md.

18. Funeral director

Edgar L. Lane

Address

Church Hill Md.

19. 1.23

1945

Fe G. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne's

City or town..... Stevensville
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 23 1945

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 22 1945 Jan. 23 1945

and that I last saw her alive on Jan. 23 1945

Immediate cause of death

coronary thrombosis

Due to myocardial degeneration

Due to general arteriosclerosis

Other conditions cerebral embolism with

hemiplegia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Theodor Sattelmayer M.D.

M. D. or other

Address..... Stevensville Date signed Jan. 23, 1945

RECEIVED

FEB 6 1945

BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00794

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH:

County

QUEEN ANNE

City or town

SANDTOWN MR SWALERSVILLE

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

LEZY NURSING HOME

Stay in hospital or inst. (yrs., or mos., or days)

10 MONTH

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Elmer Walker Newton

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widower

6(b) Name of husband or wife

Rose Newton

7. Birth date of deceased (mo., day, yr.)

7-19-1892

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Kent County

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name Joseph Edward Newton

MOTHER

13. Birthplace Kent County

14. Maiden name Catherine Wood

15. Birthplace Kent County

16. Informant Anna Newton Sister

Address

Chesterstown, Md

17. Burial

Date thereof 1-20-1945
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chester

Location

Chesterstown, Maryland

18. Funeral director J. Willis Wells

Address

Chesterstown, Md

19. Jan. 19 1945 Edgar L. Lane

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

KENT

City or town

CHESTER TOWN

Ward No.

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 18th

1945, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1st 1945, to Jan 18th 1945, and that I last saw him alive on Jan 18th, 1945.

Immediate cause of death

Pneumonia

DURATION

13

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

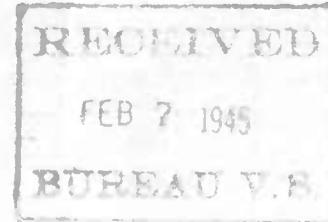
G. P. Coffland

M. D. or other

Address Mulligan

Date signed Jan 25, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

00795

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County.....

City or town.....

QUEEN ANNE'S
SUNDERSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

PALMONTORY NURSING HOME

How long in hospital or institution?.....

6 month

3. (a) FULL NAME

LILLIAN BENTON PRICE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Undivided

6. (b) Name of husband or wife.....

LEVE PRICE

7. Birth date of deceased (mo., day, yr.)

Sept. 18, 1879

(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Maryland
(Town, county, and state)

10. Usual occupation.....

Nurse

11. Industry or business

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial (Burial, cremation, or removal, Which?)

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Dated rec'd by registrar)

Date.....

1945

Edgar L. Lane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan. 1

1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945, to 1945, and that I last saw him alive on 1945.

Immediate cause of death.....

Pneumonia / Persest

DURATION

Due to.....

Due to.....

Pneumonia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

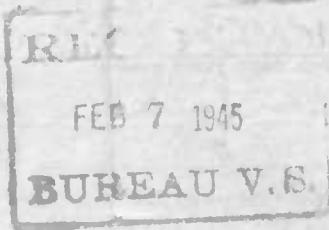
C. Dufcell

M. D. or other

Address.....

Patterson

Date signed Jan. 1, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 111252

1. PLACE OF DEATH:

County Green Anne's
City or town Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Baby Boy Scott

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Black

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 19, 1945

deceased (mo., day, yr.)

Years Months Days If less than one day

7 hrs. 30 min.

9. Birthplace Centreville, Queen Anne's Co., Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... unknown

13. Birthplace

14. Maiden name Lorraine Scott

15. Birthplace Centreville, Md.

16. Informant Lorraine Scott

Address Centreville, Md.

17. Disposal of body Date thereof Jan 20, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory At home

Location in Centreville

18. Funeral director

Address Centreville, Md.

19. Date rec'd by registrar Jan 20, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's

City or town Centreville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural - Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19, 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19, 1945, to Jan 19, 1945

and that I last saw him alive on Jan 19, 1945

Immediate cause of death

Anoxemia

DURATION

6 hr

Due to Pre-mature birth

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

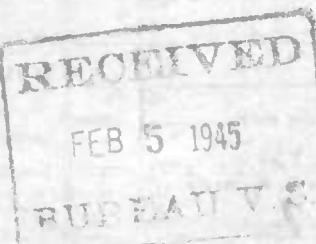
Means of injury Injured at work?

23. SIGNATURE C.R. Payton M.D.

M. D. or other

Address Centreville, Md. Date signed Jan 20, 1945

RECEIVED TO TRANSMISSION STATE THAIYAN



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

115-6

111797

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

Queen Anne
County Maryland
City or town Stonewall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Henry Williams

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Carrie Colick Hagley

7. Birth date of deceased (mo., day, yr.) Jan 14 - 1873 6. (c) If alive, give age 68 years

8. AGE: Years Months Days It less than one day 71 11 22 hrs. min.

9. Birthplace Deep Forest Wales (Town, county, and state)

10. Usual occupation Retired Contractor

11. Industry or business Heating & Plumbing, John Williams

12. Name John Williams

13. Birthplace Deep Forest Wales

14. Maiden name Henrietta Sutler

15. Birthplace England

16. Informant Grace M. Williams

Address 1800 N. Charles St Baltimore Md

17. Burial Cemetery or crematory Parkwood

(Burial, cremation, or removal. Which?)

Date thereof Jan 8 - 1945

(month) (day) (year)

Location Taylor Ave Talbot County

18. Funeral director T. A. T. T. T.

Address Centreville Maryland

19. (Date read by registrar) 1945

F. C. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Queen Anne
Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31, 1944, to Jan. 5, 1945, and that I last saw him alive on Jan. 5, 1945.

Immediate cause of death acute pyelitis and nephritis

Due to acute uremia 5 days.

Due to acute uremia 2 days.

Other conditions hemolytic strepto. 4 days

cocca throat &

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Steevesville 115745 Data signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

00798

CERTIFICATE OF DEATH

Reg. Dist. No. 252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

1. PLACE OF DEATH:

County... BaltimoreCity or town... Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

Robert L. Moore

3. (a) FULL NAME

Baby Wilmer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleCaucasianSingle

6. (b) Name of husband or wife...

7. Birth date of deceased (mo., day, yr.)

Jan 2, 1945

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace...

Centreville 2.A.C. Md

(Town, county, and state)

10. Usual occupation...

None

11. Industry or business

MOTHER FATHER

12. Name...

Calvin Wilmer

13. Birthplace

Centreville Maryland

14. Maiden name...

Mary Ellen Brown

15. Birthplace

In Centreville Md.

16. Informant

Calvin Wilmer

Address

Centreville Md

17. Burial

(Burial, cremation, or removal which)

Date thereof Jan 3-45

(month) (day) (year)

Cemetery or crematory

Puritan

Location

In Centreville Maryland

18. Funeral director

Robert Bear

Address

Centreville Md

19. Date rec'd by registrar

1-3-451945Elin Armstrong

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty 2.A.C.City or town... Centreville

(If outside city or town limits, write RURAL and give nearest town)

Street No...

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jan 3

1945

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 - 1945 to Jan 3 1945
and that I last saw him ~~alive~~ alive on Jan 2 1945

1945

Immediate cause of death...

Premature birth (6 mos.)

DURATION

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings or operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. D. Fisher

M. D. or other

Address...

Centreville MdDate signed 3-8-45

